Meeting Minutes
Health Information Technology Council Meeting

March 10, 2014
3:30 – 5:00 P.M.

One Ashburton Place, Ashburton Café Conference Room
Boston, MA

Meeting Attendees

Name	Organization	Attended
John Polanowicz	*(Chair) Secretary of the Executive Office of Health and Human Services*	Yes
Manu Tandon	*(Chair) Secretariat Chief Information Officer of the Executive Office of Health and Human Services, Mass HIT Coordinator*	Yes
William Oates	*Chief Information Officer, Commonwealth of Massachusetts*	No[1]
David Seltz	*Executive Director of Health Policy Commission*	No
Aron Boros	*Executive Director of Massachusetts Center for Health Information and Analysis*	Yes
Laurance Stuntz	*Director, Massachusetts eHealth Institute*	Yes
Eric Nakajima	*Assistant Secretary for Innovation Policy in Housing and Economic Development*	No
Patricia Hopkins MD	*Rheumatology & Internal Medicine Doctor (Private Practice)*	Yes
Meg Aranow	*Senior Research Director, The Advisory Board Company*	No
Deborah Adair	*Director of Health Information Services/Privacy Officer, Massachusetts General Hospital*	Yes
John Halamka, MD	*Chief Information officer, Beth Israel Deaconess Medical Center*	No
Normand Deschene	*President and Chief Executive Officer , Lowell General Hospital*	Yes
Jay Breines	*Executive Director, Holyoke Health Center*	Yes
Robert Driscoll	*Chief Operations Officer, Salter Healthcare*	Yes
Michael Lee, MD	*Director of clinical Informatics, Atrius Health*	Yes
Margie Sipe, RN	*Performance Improvement Consultant, Massachusetts Hospital Association (MHA)*	No
Steven Fox	*Vice President, Network Management and Communications, Blue Cross Blue Shield MA*	Yes
Larry Garber, MD	*Medical Director of Informatics, Reliant Medical Group*	Yes
Karen Bell, MD	*Chair of the Certification Commission for Health Information Technology (CCHIT) EOHED*	Yes
Kristin Madison	*Professor of Law and Health Sciences, Northeastern School of Law, Bouve college of Health Sciences*	Yes
Daniel Mumbauer	*President & CEO, Southeast Regional Network, High Point Treatment Center, Southeast Massachusetts Council on Addiction (SEMCOA)*	No
Kristin Thorn (acting)	*Director of Medicaid*	Yes

Guest

Name	Organization
Robert McDevitt	EOHHS
Nick Welch	EOHHS
Kathleen Snyder	EOHHS

[1] Claudia Boldman was a delegate for Bill Oates

Name	Organization
Claudia Boldman	ITD
Jennifer Monahan	MAeHC
Micky Tripathi	MAeHC
Mark Belanger	MAeHC
Lisa Fenichel	Consultant
Adrian Gropper	MMS and PPR
Dave Bowditch	EOHHS
Gorden Burke	EOHHS
David Smith	MHA
David Bachard	Neqca
Sarah Moore	Tufts MC
Nelson Gagnon	Orion
Pam May	Partners
Pat Rubalcaba	Partners
Ann Hwang	EOHHS
Sarah Moore	Tufts Med
Jay Desai	PatientPing

Meeting called to order – minutes approved

The meeting was called to order by Manu Tandon at 3:38 P.M.

The Council reviewed minutes of the February, 2014 HIT Council meeting. The minutes were approved as written.

Discussion Item 1: Mass HIway Update (Slides 3-14)

See slides 3-14 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

An update on the Mass HIway was presented by Manu Tandon, Executive Office of Health and Human Services (EOHHS) Secretariat Chief Information Officer and Massachusetts Health IT Coordinator

(Slide 4) Primary Uses of HIway to Date – One of the questions raised at the last meeting was around use cases now versus when we last presented in December. Care coordination has spiked- numbers were low in the beginning but we are starting to see this pick up. Public Health also picking up with help of meaningful use reporting requirements. Care management and Quality Reporting are flat in terms of growth.

- Question (Patricia Hopkins): Is care coordination sending discharges to nursing homes?
    - Answer (Laurance Stuntz): Within the Massachusetts eHealth Institute's (MeHI) grantees we are trying to document more specifics with use cases. Right now this number

encompasses any type of coordination. The use case can be determined by organization type.

- Question (Patricia Hopkins): Does the patient need to opt into this?
    - Answer (Manu Tandon): Yes, they need to opt-in for the sharing of information over the HIway.
- Question (Patricia Hopkins): How would a small group opt in patients, on paper?
    - Answer (Manu Tandon): There is a consent discussion coming up today- essentially consent happens between the provider and the patient- The Executive Office of Health and Human Services (EOHHS) does not keep a record of that. As providers onboard to the Health Information Exchange (HIE) they begin to understand what the requirements are, which are explained in the Participation Agreement (PA). It is a division of labor- provider takes care of the consent aspect while the HIE makes sure the data is sent safely from one point to another.
- Question (Patricia Hopkins): Ideally your Electronic Medical Record (EMR) should take care of the encryption?
    - Answer (Manu Tandon): Yes- if they do not have the native capability some are using the Local Access Network Distribution (LAND) device or webmail.
- Question (Claudia Boldman): How do you know what the use cases are? Is it a field somewhere?
    - Answer (Mark Belanger): We are interpreting by who is sending. The HIway has no idea who or what the transaction is about by design. All that can be inferred is the sender and receiver. Care coordination means the transaction was between 2 providers. Case management means the transaction was between a provider and payer. Public health reporting means that a Public Health agency was on one end of the transaction. Quality Reporting means that there was a quality data service on one end of the transaction.

(Slide 5) Phase 2 Rate Card Analysis - The HIE is largely funded using Medicaid dollars. In Phase 1- send and receive- the private share had to be in the $700k range. In Phase 2 - Query & Retrieve Services - it is about $550k that needs to be collected annually. Combined it will be 1.3 million. We are ahead of the game in terms of collection for Phase 1. The folks in the current pipeline will provide an additional $500k - $700k.

Micky Tripathi, CEO of the Massachusetts eHealth Collaborative, presented information on the Phase 2 Rate Card

This is the currently proposed rate card- looking for Council feedback.

(Slide 5 Cont.) Phase 2 Rate Card Analyses – The Centers for Medicare and Medicaid Services (CMS) certainly does not care how you get to the 1.3 million dollar mark- they just want to make sure you get there. The realized revenue has already exceeded the $500,000 range and there are still close to 100 organizations fully committed in the pipeline. If we apply the tiered rates it gives us a projection of $700,000. In prior discussions we had said we would not charge for Health Information Service Provider (HISP) to HISP connections - even with all of that stripped out we are still in a good position.

The pricing needs to take into consideration the number of customers as well as who is likely to purchase what services. Ideally we want the pricing to accomplish a few things: Meet the CMS matching requirements and minimize barriers to entry. We do not want to set the price too high- especially with the Chapter 224 and Public Health connectivity requirements and penalties. There is a need to keep the prices down for small providers and underserved areas.

(Slide 6) Phase 2 Rate Card – Right now Phase 2 rates are roughly at 50% of the Phase 1 pricing. As a reminder you are not required to use all of the Phase 2 services. The idea is that they pay their Direct messaging fee and if they want to use query-retrieve they would pay the additional money for the complete service.

With all of those considerations in mind we were aiming for greater flexibility to see how we can drive down prices and reduce adoption barriers. The more people on the HIway, the more valuable the service.

Market penetration suggests that the Phase 2 services will be very attractive to customers – query and retrieve is the higher value. The service value increases exponentially as organizations join. If all 71 customers, who have already paid for Phase 1 decide to pay for Phase 2 we would already have almost half of what is required. We may end up with an overage in what we are collecting.

- Comment (Larry Garber): As we look at Phase 1 right now, the hospitals are dealing a lot with matching Medical Record Numbers (MRN), for instance if I am sending records to St. Vincent's they are not going to be able to file the information until I send back the record numbers. As we go to Phase 2, the more value we can provide with that matching the better. We have the mapping of all of the MRN's- if we could query those it may really drive up interest in the Phase 2 functionality.
    - Response (Micky Tripathi): In the current design we are anticipating that a provider will log into a portal and provide basic demographic information. If you actually went to the portal you can make the request, as part of that we do send the MRN number. All of this depends on clean data coming in- clean ADT's and having enough volume. I think what you are suggesting is the "connecting the dots" piece- not just market this as an RLS but also a MRN mapping service.
- Question (Patricia Hopkins): What if the patient visits 3 different sites with three different numbers?
    - Answer (Mike Lee): Today in our portal if I match Larry Garber with the same Larry Garber at Beth Israel Deaconess (BID) I store his MRN from BID. If we could share the already matched identities it would be a great benefit.
- Question (Mike Lee): Does this keep us cash positive? I am great with dropping the rate down, but we obviously want this to survive. The last thing we want to do is go back and ask participants for more money.
    - Answer (Secretary Polanowicz): I think the combination of the lower rates, meaningful use and Chapter 224 requirements will make this possible. We are looking at putting in requirements around connection and use of the HIway into some of the grant programs

we have for hospitals. Certainly the second round of CHART grants will start to drive the requirements to be on by 2017.
    - Answer (Manu Tandon): I think we are in a good place-we are excited that we are able to provide the services at this price point.
- Question (Laurance Stuntz): Do you anticipate anyone just signing up for Phase 2 services?
    - Answer (Manu Tandon): You cannot start with Phase 2, but customers can just sign-up for Phase 1 services.

(Slide 7) HIway Release Schedule- There are three new items on the calendar. Webmail upgrade in April- which will provide a way to access the HIway to send and receive Direct compliant messages. The Meditech External Data Representation (XDR) Solution will go-live in April. Meditech is not requiring a vendor specific HISP, they have added an enhancement which will allow them to connect using XDR, supporting Direct. The HISP to HISP solution will go-live in April.

The eReferral Node go-live will be in June. There is a referral function that DPH provides- they are looking to increase communication with community based organizations.

The Lead Poison Prevention Program Node go-live date will be sometime in Quarter 3 of 2014. We will finalize the date for the Lead Poisoning and the Phase 2, release 2 soon. The Master Patient Index (eMPI) tuning will also be happening- the Initiate product needs to be trained on the different matching algorithms but you can only do this when there is a certain amount of customers on-board (right now there is no data to work with). It will have security integrations and some provider notification functionality. We will also finalize a date on the healthcare provider portal.

(Slide 8) Outreach and Communications Update – Amy Caron has been working with the outreach team and they have drafted patient education materials, staff training materials, Frequently Asked Questions (FAQ's) and implementation plans. We are preparing a document for the Portal and Provider Directory roll out. There is also work being done to develop a set of learning series- including how to execute the PA.

(Slide 9) HIway Operations Update – In February we saw four new PA's signed- total is now 132.

(Slide 10) HIway Operations Update Cont. – Cambridge Health Alliance was the 100th organization to go-live. Since then we have added four more. January was the booster month thanks to the Last Mile program and meaningful use incentive payments.

(Slide 11) HIway Operations Update Cont.- We are seeing a steady volume- a large number of organizations have joined the HIway, but we have yet to see the corresponding increase in volume as we are still in early stages of HIway growth.

(Slide 12) HIway Operations Update Cont. – The team has a goal of connecting 135 organizations on the HIway by June 30th. Key drivers for growth are the public health nodes and HISP members that will be enabled in the April/May timeframe. In terms of the HISP to HISP connections, we have not accounted

for the mushrooming that could happen behind the HISP- hundreds using the HISP can join under the HISP. Right now we are taking a conservative approach to quantifying the numbers.

- Question (Larry Garber): Is Public Health planning to do a Cancer Registry?
    - Answer (Manu Tandon): Yes- starting in April 2014. They are actually the one node getting advance bookings- signing-up before on-boarding. It is not a Core requirement, but is a driver.

(Slide 13) HISP to HISP Connectivity – There are three flagship HISP's- Surescripts, eClinicalWorks and Secure Exchange Solutions (SES). Additional vendors indicating readiness were provided. Meditech and Epic will not be using HISP – should be able to get them on in April. Epic can already send and receive Direct messages.

(Slide 14) Phase 2 Implementation Plan- We wanted to show where we are in terms of getting the ADT's sent to the HIway. We are working with the four early adopters- there are two parallel paths. One is the technology configuration which changes by organization; the second is developing a new consent process. In order to develop the consent processes we have been working with the Advisory Groups. As of now we have a draft under review- teed up to be reviewed with Consumer, Provider and Consent Sub-Group again mid-month. We will do a quick review at EOHHS and should be ready in April to finalize. That will then be triggered back to the early adopters. BIDMC is planning to complete the tech operations in April with testing in early May- the goal is to move to full production in the mid- May timeframe. The initial implementation would be technical, towards the first week of July when they have the agreements in place they will start to send information based on who has consented.

Holyoke is leading the charge and as the consent is finalized they will take a short three weeks to roll it out and will start sending ADT's around May – about 7,000 ADT's per month. Tufts and Atrius do not yet have a defined timeline, but we are working with them now. Tufts needs to get to the consent finalized, with Atrius I think it is a help dialogue right now. As said earlier, the outreach program will target more providers.

- Question (Lisa Fenichel): What is an ADT?
    - Answer (Micky Tripathi): It stands for Admit – Discharge - Transfer. It is a standard message that happens when any of those three events happen.
- Comment (Deborah Adair): Partners is not on the list but we are on the same timeline. We were talking before about the importance of getting trading partners in there. Our plan is to use this for all of the transitions of care (TOCs).
- Question (Mike Lee): Right now everyone is working on the ability to send, not really receive. Our biggest challenge right now is meeting the 10% TOC threshold for meaningful use. If we do not have anyone receiving it will be hard to meet that number. How will CommonWell Health Alliance, Healtheway and other national vendor "get togethers" impact us? How do you see those playing out?
    - Answer (Micky Tripathi): I think CommonWell and Surescripts could very much effect what we do. Both are implementing using a query- retrieve architecture which is

identical to ours. Surescripts demonstrated this on their platform at the last Healthcare Information and Management Systems Society (HIMSS) meeting. There are a number of ways of doing this- it will not solve all of the problems. CommonWell and Epic will likely be vendor specific. The HIway in theory is the only one that cuts across the vendors.

- Question (Larry Garber): Are they using the standard Information Advice and Guidance?
    - Answer (Micky Tripathi): Yes- right now doing XDA at CommonWell. It also raises issues that this might cause serious workflow issues. MAeHC is using CommonWell and the HIway- CommonWell does not ask for things, while the HIway does.
    - Comment (Mike Lee): CommonWell was an EHR vendor, so if you were outside you could not participate. It is all confusing.
- Question (Patricia Hopkins): Have we looked at Pharmacy Benefit Managers (PBM's)- what if I want to see the prescription for a patient for the last 5 years for example? Will they participate on the HIway? Historical data- does not go back far enough. Might be worth considering in terms of revenue.
    - Answer (Micky Tripathi): Most of that you get that information via Surescripts- EHR's are required to do this.
    - Comment (Manu Tandon): I think the philosophy is HIway as the transporter, we would need to look at a business case. What would be the advantage?
- Question (Laurance Stuntz): Is that the plan to provide data that old?
    - Answer (Patricia Hopkins): The formularies are constantly changing, Blue Cross is like a moving target. I am talking about something providers want as we move towards things like global payment.
    - Comment (Steve Fox): I think we would be losing an opportunity if we do not discuss this with them.

Discussion Item 2: Policy Advisory Group Update (Slides 15-21)

See slides 15-21 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

Advisory Group updates were presented by Micky Tripathi, CEO at the Massachusetts eHealth Collaborative.

At the last HITC meeting we talked about the Advisory Groups and the consent discussion feedback. We now have a Consent Sub-Group which consists of a group of providers who have been thinking about the issues around operationalizing consent. Last meeting we had a recommendation that came out of that- no change in Phase 1- in Phase 2 we will have a two part approach, a simple consent but have a template – recommended not required – have educational materials which would be the place to educate the patient. We also said we would have standard educational materials.

Since that last meeting the only change now is that the educational materials will not be required- but for there to be a contractual obligation to have the organization educate the patients on the RLS etc- not require they have to use this form, the idea is to make all of the participants "on the hook" for educating

the patient, but allow them to coordinate it in a way that makes sense in their setting. There is a lot of complexity- there are organizations that need flexibility in terms of how they put that together. Everyone will have their own unique way of communicating those things.

So far, the consent policy statement and educational materials that have been drafted (one high level pass with Consumer). Now we have the draft educational materials with a health literacy consultant. There will be an additional review with the Consumer, Provider and Consent Groups. Again, their contractual requirement is to educate the patient, just not with required materials.

- Question (Lisa Fenichel): What does to be "on the hook" mean- is there a way to access whether or not they are educated? Monitoring programs?
    - Answer (Micky Tripathi): The contract does say that HHS can audit any organization in terms of their adherence.
- Question (Meg Aranow): There are a lot more rules around sensitive conditions - has there been discussion around consent with those patients?
    - Answer (Micky Tripathi): The way Commonwell is doing it right now is to treat this as a general request for information. If there are special considerations then those data holding entities are responsible for what is sent. The presumption is that the data holding entity is in charge, which is how this is done today. Also, this will not work with HIV right now because you need the consent every time.

(Slide 16) Advisory Group Update – skipped

(Slide 17) Advisory Group Update Cont. – skipped

(Slide 18) HIway Consent Policy – The goal is to have the cleanest, most simple form possible- the idea is that there would be user guides, training for staff, policies and procedures to accompany the PA.

The participant is responsible for obtaining permission. In Phase 1 the participant is solely saying "OK" to Direct messaging, now the patient needs to give the "OK" to transmit health information- the form must identify the HIway as one of the organizations involved in the process.

There are nuances to point out- focusing a lot on transmission and disclosure of information. If we didn't spell a lot of this out, someone could interpret this to mean that every party needs to get consent. We need to explain that this is about transmission of information- and that is where the point of consent is.

The idea now is that the participant must get permission to transmit specified demographics to the HIway RLS (ADT messages) - only some fields are kept for matching purposes and that data is stored - and it discloses the participant's record location. Participants need permission from the patient to have that information sent and stored- and the patient should understand what that means- a relationship between the patient and the organization will be disclosed under the Terms of Access. That does not mean that any user can look at the RLS - only organizations that can look me up are ones where I have consented to let them display our relationship on the RLS. Break the Seal functionality, which triggers a hard audit, will only be enabled for Emergency Room providers.

- Question (Larry Garber): I am not an ER physician but I have emergency situations - does that mean I cannot do this?
    - Answer (Micky Tripathi): Yes- we need to restrict users right now-one big challenge is how to avoid people self-identifying themselves falsely as ER providers. This could mature to something more complex- a subset for now
- Question (Adrien Gropper): Now that we have two different consents, can we revisit the restraints on using Direct messaging? Which groups, for example at MMS- physicians who do not have an active license, could use the HIway? If we are separating this from HIPPA to query-retrieve, versus others under a White List, do we need to have a high barrier?
    - Answer (Manu Tandon): I would be happy to take a look at that and get back to you.
    - Answer (Kathleen Snyder): Right now, we are clearly limiting use to those involved with patient treatment, payment, and operations as defined by HIPAA.
- Question (Patricia Hopkins): In taking the demographics are you then giving them a number?
    - Answer (Manu Tandon): No, there is no intent here of giving patients a universal ID- we will de-duplicate using the Initiate software.
- Question (Patricia Hopkins): What about with physicians – when doctors retire and are no longer active, where does the consent go? I am thinking about all of the data in my system of thousands of patients and that will at some point stop. What happens to the information that has been there?
    - Answer (Micky Tripathi): good point, even could say that about any clinical "termination"
    - Comment (Patricia Hopkins): It is going to be an issue with the age of the physicians- the decade of adoption.
    - Comment (Secretary Polanowicz): If a physician retires now they are required to keep a 7 year look back. I find for most physicians who send over a Medical Release Form (MRF) they send it over because they do not want to maintain the records for 7 years.
    - Comment (Micky Tripathi): If a legal entity is no longer in existence than the RLS is meaningless. There would be no basis for having them listed anymore.

- Question (Mike Lee): What is the mechanism if provider A joins practice B?
    - Answer (Manu Tandon): That is data we cannot manage right now.

(Slide 19) HIway Consent Policy Cont. – We are in the process of creating materials now- but there is no specified time limit for consent- must be appropriate to the level the organization is at. A new consent needs to be obtained if you have consented patients only for Direct- if you move to query retrieve you need to go back and get a higher level of consent because you are introducing something new. Although, a participant can get consent for query and retrieve in advance to avoid this. The other factor that could change things is adolescents – participants have to re-consent patients as they reach the age of majority or are considered emancipated minors.

A patient can change the consent preference and the practice is responsible for updating the consent. The HIway will expect a new ADT is sent. There will also be audit logs- part of HIPAA providers must have

audit logs available. The HIway will have those available upon request- but again the HIway does not know what is in the package.

- Comment (Mike Lee): On the adolescent issue- is the legal guardian the only one that can give consent? Are we saying that the consent cannot be given by the teenager? I think it is cleaner to say that the legal guardian should be the one to decide.
- Comment (Larry Garber): I think one thing too is that when we give patients access to inboxes we will need a whole new ground of consent.

The template being offered is the simple consent form. There is the requirement for a two-part consent and educational materials will explain what the consent means. If you wanted to add more you could. In terms of providing the detail the consensus is that it should be in the education materials.

- Comment (Patricia Hopkins): Right now it says at age 18 they need to be re-consented, but does not say they cannot consent for themselves. What it should say is that at that point we need their consent.
- Comment (Mike Lee): Those questions- can that kid consent, but maybe not that one? We need to make that clear so there is a single standard- those questions will come up.
- Comment (Micky Tripathi): There is a mature minor standard around things like birth control, abortion etc., so the question is could a teen, when not in contact with their guardian, give consent. It would be better not to make that organization specific. Often a lot of those issues will be masked by the crudeness of the RLS, but you could imagine an issue if the patient went to Planned Parenthood for example. You do not necessarily need that solved on day one, since it's still an issue today.
- Comment (Deborah Adair): We have policies with our patient portal in terms of age, we could look at that for models.
- Comment (Micky Tripathi): Most repository HIE's punt this- once you reach 13 you disappear completely and only show up again as a person when you reach 18.

(Slide 20) Refining Consensus on Consent – skipped

(Slide 21) Answers to February Questions – We addressed the time limits, re-consent policies at 18 needs work, potential uses for treatment and payment operations (TPO) and change in consent for mass education materials- no longer relevant in a way because there will not be standardized materials. If there is a change in functionality it is expected the organization will re-educate patients.

- Question (Lisa Fenichel): In terms of the patient portal stuff- what is the thought on that in terms of having access.
    - Answer (Manu Tandon): The goal is to eventually enable a portal. Right now there is a business process barrier. We will also need to build enough ADTs before this would happen.
    - Comment (Laurance Stuntz): MeHI has been talking to NexJ and No More Clipboard which are both patient facing.

Discussion Item 3: Last Mile Program Wrap-up (Slides 22- 29)

See slides 22-29 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

The Last Mile Program wrap-up was provided by Laurance Stuntz, MeHI Director.

As mentioned, NextJ and No More Clipboard are two patient facing vendors- even though the Last Mile Grant does not cover them, we will consider them an active participant and we want them to roll out as an example.

(Slide 23) ONC Grant Close Out Activities – The grants ended from a funding perspective- in the middle of cleaning it up. Mid to late April will start to assess the impact.

(Slide 24) State HIE Grant: Accomplishments – skipped

(Slide 25) State HIE Grant: Lessons Learned – skipped

(Slide 26) State HIE Grant: Gap Analysis – ONC on the HIE side is sweeping up all of the money that the HIE grants did not spend across the country- they have said in the fall timeframe they will push out other opportunities. They're gathering ideas now for the design of that- will need to see how much money is leftover after the ARRA funding.

(Slide 27) State HIE Grant: Feedback to ONC- We have told them we need to concentrate on the vendors, things around Direct Trust standards, focusing on showing people how they can use the HIE to reduce costs.

(Slide 28) Last Mile Program Transition Planning – As MEHI and HIway Ops move to the next phase, the Ops team is working on communication while MeHI is looking at adoption and connectivity. We are taking lessons learned from early adopters and sharing them with the community. At the HIway level we can only see that there is a provider to provider transaction- we want to dig down a level and create a use case library. We have been updating a map to show what people are doing by geographic location- we are pulling that information out into a learning/webinar series- now that you are live, now what? How do I operationalize this?

HIway grants do continue- we said through this fiscal year. Almost all grantees tested, but only a few are live and transacting in production mode. We are continuing to track grantees and push those along. MAeHC is helping with those efforts.

We are also planning for Impact or Outcome grants- now that these organizations are on the HIway we would like to see organizations sign up for specific use cases that can be tracked. Looking to scope a program right now- looking for HITC feedback on that.

- Comment (Aron Boros): I would start with someone like Atrius- have them determine what the most valuable thing has been with HIway use.

- Comment (Larry Garber): One of the things we have seen is that because we have real time interfaces and we are finding out about discharges, we have seen great follow ups- usually within a week of discharge. That is not necessarily an outcome, but certainly is helpful.

(Slide 29) The Rally- #MassHIway Transact-a-thon – Thanks to the organizations that participated! People were excited about this- ONC seemed to appreciate it.

Discussion Item 4: MeHI Update (Slides 30-37)

See slides 30-37 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

An update on MeHI activity was provided by MeHI Director Laurance Stuntz.

Laurance will continue his update during the next Council meeting.

(Slide 32) Statewide Electronic Health Records Planning – skipped

(Slide 33) EHR Adoption Preliminary Survey Results – We just received the results of the survey- we will hopefully bring this to the next meeting for review. We went out to about 500 provider organizations and 800 consumers and got some good info on adoption. In particular organizations affiliated with others are already almost there in terms of HIT adoption. We dug into the numbers and almost every facility is affiliated or owned by a for- profit network. The survey is helping focus the efforts.

(Slide 34) Key Needs of Providers in Massachusetts – skipped

(Slide 35) Outreach and Engagement Methods – skipped

(Slide 36) Regional Extension Center Grant Extension – skipped

(Slide 37) eHealth Cluster Development – skipped

Discussion Item 5: Wrap-Up (Slides 38-39)

See slides 38-39 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

Schedule for 2014 HIT Council Meetings:

- ~~January 13th~~
- ~~February 3rd~~
- ~~March 10th~~
- April 7th -- back in the usual location
- May 5th
- June 9th
- July 7th
- August 4th
- September 8th

- October 6th
- November 3rd
- December 8th

The Next HIT Council Meeting is scheduled for **April 7, 2014** from 3:30pm-5pm at One Ashburton Place, 21th floor, Conference Room 1&2.

The HIT Council meeting was adjourned at 5:01 P.M.